OCCUPATIONAL THERAPY PROGRAM  
Department of Rehabilitation Science  
School of Public Health and Health Professions  
University at Buffalo  
The State University of New York  
501 Stockton Kimball Tower  
Buffalo, NY  14214

VOLUNTEER EXPERIENCE FORM

APPLICANT’S NAME _________________________________________

I hereby waive my right to inspect this form and attachments of continuation. I understand I may not be required by the institution to waive that right as a condition for admission.

Date _______________________   Student Signature _______________________________________________________________

PLEASE NOTE: If the student does not sign the statement, the law specifically reserves to the student the right of access to the letter in question.

The above-named individual, who is seeking admission to our occupational therapy program, has indicated that he/she volunteered or worked at your facility.

One criterion for admission is that an applicant must complete a minimum of seventy (70) hours of experience in a United States OT setting providing direct patient/client care under the supervision of a licensed Occupational Therapist. This experience must be undertaken within two years prior to application in a maximum of two (2) settings.

During this experience, we hope that the applicant has had the opportunity to observe interdisciplinary activities; observe patients/clients in a variety of situations; and, if permitted, participated in some direct patient/care activities.

We would appreciate your verification of the applicant’s experience by completing this form and returning it to Attn: Occupational Therapy Program, Department of Rehabilitation Science, University at Buffalo, 501 Kimball Tower, Buffalo, NY 14214-3079 by January 15th. Thank you for your cooperation.

Types of clients served by your Center : __________________________________________________________________________

Total number of hours applicant participated in the volunteer experience as described above:  Hours    __________________________

Dates (please include year):  ____________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

*Quality of work:     Excellent _______   Good _______    Fair_______   Poor _______

Comments: (Additional pages may be attached)  ____________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Name of Center ______________________________________________________________________________________________

Address  ____________________________________________________________________________________________________
No./Street                                                                                                                           City/State/Zip

Supervising  Occupational Therapist:  _____________________________________________________________________________

Title _____________________________________Telephone (_____)_______________ Date _______________________________

Signature  __________________________________________________ Email  ___________________________________________

*Please note that only ratings of “Excellent” or “Good” will receive credit toward this requirement, so if you give a “Fair” or “Poor” rating, please provide us with specific information indicating why that rating was given.